UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In re:

City of Detroit, Michigan,

Debtor.

_____/

Bankruptcy Case No. 13-53846
Honorable Thomas J. Tucker
Chapter 9

EXHIBIT D (BLUE CROSS PLAN) IN SUPPORT OF DPLSA'S RESPONSE IN OPPOSITION TO CITY OF DETROIT'S MOTION FOR (I) DETERMINATION THAT THE DETROIT POLICE LIEUTENANTS AND SERGEANTS ASSOCIATION HAS VIOLATED THE TERMS OF THE CITY OF DETROIT'S CONFIRMED PLAN OF ADJUSTMENT AND THE ORDER CONFIRMING IT; AND (II) ORDER (A) ENJOINING FURTHER VIOLATIONS AND (B) REQUIRING DISMISSAL OF STATE ACTIONS [DOCKET NO. 9656]

PART 4 OF 14

Diagnostic Services

For allergy testing services, see Page 19.
For diagnostic radiology services, see Page 83.
For mental health diagnostic services, such as psychological testing, see Page 49.

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for diagnostic services in a hospital (inpatient or outpatient), ambulatory surgery facility, skilled nursing facility that participates with BCBSM or a physician's office subject to the conditions described below.

We pay for:

Diagnostic Testing

We pay for diagnostic services used by a physician to diagnose disease, illness, pregnancy or injury.

- Physician services are payable for tests such as:
  - Thyroid function
  - Electrocardiogram (EKG)
  - Electroencephalogram (EEG)
  - Pulmonary function studies
- Physician and independent physical therapist services are payable for the following tests:
  - Electromyogram (EMG)
  - Nerve conduction

  We pay for EMG and nerve conduction tests performed by an independent physical therapist if ordered by a physician. The independent physical therapist must be certified by the American Board of Physical Therapy Specialties to perform these tests.

Diagnostic Laboratory and Pathology Services

We pay for laboratory and pathology tests and services needed to diagnose a disease, illness, pregnancy or injury. Services must be provided:

- In a hospital (under the direction of a pathologist employed by the hospital) or
- By the patient's in-network physician or by another physician if your in-network physician refers you to one, or by an in-network laboratory at your in-network physician's direction.
  - Standard office laboratory tests approved by BCBSM performed in an in-network physician's office are payable. Other laboratory tests must be sent to an in-network laboratory.
  - You will be required to pay the out-of-network copayment if services are provided by an out-of-network laboratory or in an out-of-network hospital.

Dialysis Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Important: **Services for the treatment of End Stage Renal Disease (ESRD) are covered in coordination with Medicare. It is important that individuals with ESRD apply for Medicare coverage through the Social Security Administration.** (Please see Pages 3 – 4 for a detailed explanation of ESRD.)

Locations: We pay for dialysis services in an in-network or participating hospital (inpatient or outpatient), an in-network or participating freestanding ESRD facility, or in a home subject to the conditions below.

We pay for:

Dialysis services (including physician services), supplies and equipment to treat:

- Acute renal (kidney) failure
- Chronic, irreversible kidney failure (End Stage Renal Disease (ESRD))

  End Stage Renal Disease

  Covered services to treat patients with chronic, irreversible kidney disease are payable until the patient becomes eligible for Medicare (a maximum of three months from the date of applying for Medicare). After that services are covered in coordination with Medicare. Individuals with ESRD should apply for Medicare coverage through the Social Security Administration. See Pages 3 – 4 for details about ESRD.

  ESRD treatment may be provided in:

  – An in-network or participating hospital, inpatient or outpatient
  – An in-network or participating freestanding ESRD facility
  – The home (when provided by a program participating with BCBSM to provide such services)

Services Provided in a Freestanding ESRD Facility

We pay for medically necessary facility services provided by a BCBSM network or participating end stage renal (kidney) disease facility. ESRD facility services are provided to treat patients with chronic, irreversible kidney disease. (See Section 2 for how these services are paid).

We pay for:

- Use of the freestanding end stage renal disease facility
- Ultrafiltration
- Equipment

Dialysis Services (continued)

Services Provided in a Freestanding ESRD Facility (continued)

We pay for: (continued)

- Solutions
- Routine laboratory tests
- Drugs
- Supplies
- Other medically necessary services related to dialysis treatment
- Home hemodialysis
  - Continuous ambulatory peritoneal dialysis and self-dialysis training with the number of training sessions limited according to Medicare guidelines
  - Continuous cycling peritoneal dialysis (limited to 14 dialysis treatments per month) and self-dialysis training with the number of training sessions limited according to Medicare guidelines

We do not pay for:

- Services provided by a nonparticipating end stage renal disease facility.
- Services not provided by the employees of the ESRD facility.
- Services not related to the dialysis process.

Dialysis Services (continued)

Services Provided in the Home

Dialysis services (hemodialysis and peritoneal dialysis) must be billed by a hospital or freestanding ESRD facility participating with BCBSM and must meet the following conditions:

- The treatment must be arranged by the patient's attending physician and the physician director, or a committee of staff physicians of a self-dialysis training program.
- The owner of the patient's home must give the hospital prior written permission to install the equipment.

We pay for:

- Placement and maintenance of a dialysis machine in the patient's home
- Expenses to train the patient and one other person who will assist the patient in the home in operating the equipment
- Laboratory tests related to the dialysis
- Supplies required during the dialysis, such as dialysis membrane, solution, tubing and drugs
- Removal of the equipment after it is no longer needed

We do not pay for:

- Services provided by persons under contract with the hospital, agencies or organizations assisting in the dialysis or acting as "back ups" including hospital personnel sent to the patient's home
- Electricity or water used to operate the dialyzer
- Installation of electric power, a water supply or a sanitary waste disposal system
- Transfer of the dialyzer to another location in the patient's home
- Physician services not paid by the hospital

Durable Medical Equipment

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for durable medical equipment in the following locations subject to the conditions described below:

- In-network or participation hospital (inpatient or outpatient)
- Participating skilled nursing facility (see Page 85)
- In the home or for home infusion therapy (see Page 44).
- Hospice care (see Page 39)

We pay for:

- Use of durable medical equipment while you are in the hospital.
- Rental or purchase of durable medical equipment from a hospital (at the time of discharge) or from a DME supplier who meets BCBSM qualification standards, when prescribed by a physician or certified nurse practitioner.
- Medicare Part B: In many instances we cover the same items covered by Medicare Part B as of the date of purchase or rental. In some instances, however, BCBSM guidelines may differ from Medicare. Please call your local customer service center for specific coverage information.

DME items must meet the following guidelines:

- The prescription includes a description of the equipment and the reason for the need or the diagnosis.
- The physician writes a new prescription when the current prescription expires; otherwise, we will stop payment on the current expiration date, or 30 days after the date of the patient's death, whichever is earlier.

If the equipment is:

- Rented, we will not pay for the charges that exceed the BCBSM purchase price. Participating providers cannot bill the member when the total of the rental payments exceeds the BCBSM purchase price.
- Purchased, we will pay to have the equipment repaired and restored to use, but not for routine periodic maintenance

Durable Medical Equipment (continued)

We pay for: (continued)

Continuous Positive Airway Pressure (CPAP)
When prescribed by a physician, the CPAP device, humidifier (if needed) and related supplies and accessories are covered as follows:

- We will cover the rental fee only for the CPAP device and humidifier. Our total rental payments will not exceed our approved amount to purchase the device and humidifier. Once our rental payments equal the approved purchase price, you will own this equipment and no additional payments will be made by BCBSM for the device or humidifier.
  - We will pay for the purchase of any related supplies and accessories.
- After the first 90 days of rental, you are required to show that you have complied with treatment requirements for BCBSM to continue to cover the equipment and the purchasing of supplies and accessories. The CPAP device supplier must document your compliance.
- If you fail to comply with treatment requirements, you must return the rented device to the supplier or you may be held liable by the supplier for the cost of continuing to rent the equipment.
  - If you fail to comply with treatment requirements, we will also no longer cover the purchase of supplies and accessories.

We do not pay for:

- Exercise and hygienic equipment, such as exercycles, Moore Wheel, bidet toilet seats and bathtub seats
- Deluxe equipment, such as motorized wheelchairs and beds, unless medically necessary and required so that patients can operate the equipment themselves
- Comfort and convenience items, such as bed boards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms or air conditioners
- Physician's equipment, such as stethoscopes
- Self-help devices not primarily medical in nature, such as sauna baths and elevators
- Experimental equipment

Emergency Treatment

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For urgent care services, please see Page 110.

Locations: We pay for services to treat medical emergencies and accidental injuries in a hospital, participating ambulatory surgery facility, urgent care center or physician's office subject to the conditions described below. (A participating ambulatory surgery facility is considered an in-network provider.)

We pay for:

Facility and physician services to examine and treat a medical emergency or accidental injury.

For a definition of "emergency services," see Section 7.

Home Health Care Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for care and services provided in the patient's home as an alternative to long-term hospital care. Home health care must be:

- Prescribed by the attending physician
- Provided and billed by a **participating** home health care agency
- Medically necessary (as defined in Section 7)
- The following criteria for home health care must be met:
- The attending physician certifies that the patient is confined to the home because of illness.
- This means that transporting the patient to a health care facility, physician's office or hospital for care and services would be difficult due to the nature or degree of the illness.
- The attending physician prescribes home health care services and submits a detailed treatment plan to the home health care agency.
- The agency accepts the patient into its program.

We pay for:

Services provided by health care professionals employed by the home health care agency or by providers who participate with the agency in this program. The agency must bill BCBSM for the services. They are:

- Skilled nursing care provided or supervised by a registered nurse employed by the home health care agency
- Social services by a licensed social worker, if requested by the patient's attending physician
- Physical therapy, speech and language pathology services and occupational therapy, as described on Pages 53, 66 and 88 are payable when provided for rehabilitation.

Home Health Care Services (continued)

We pay for: (continued)

- If equipment for therapy and speech evaluation cannot be taken to the patient's home, therapy and speech evaluation in an outpatient department of a hospital or a freestanding outpatient physical therapy facility are covered under outpatient benefits and are subject to the 60-visit maximum as described on Page 68.

- Part-time health aide services, including preparing meals, laundering, bathing and feeding **if**:

  – The patient is receiving skilled nursing care or physical or speech therapy

  – The patient's family cannot provide the services **and** the home health care agency has identified a need for these services for the patient to participate in the program

  – The services are provided by a home health aide and supervised by a registered nurse employed by the agency

We pay the following covered services when the home health care is provided by a **participating** hospital:

- Lab services, prescription drugs, biologicals and solutions related to the condition for which the patient is participating in the program

- Medical and surgical supplies such as catheters, colostomy supplies, hypodermic needles and oxygen needed to effectively administer the medical treatment plan ordered by the physician

We do not pay for:

- General housekeeping services
- Transportation to and from a hospital or other facility
- Private duty nursing
- Elastic stockings, sheepskin or comfort items (lotion, mouthwash, body powder, etc.)
- Durable medical equipment
- Physician services (when billed by the home health care agency)
- Custodial or nonskilled care
- Services performed by a nonparticipating home health care provider

Hospice Care Services

See Page 14 in Section 2 for what you may be required to pay for these services.

Locations: We pay for hospice care services in a hospice facility, hospital, or skilled nursing facility that participates with BCBSM. We also pay for hosice care servies in the home (see Page 123 for when services may be payable in a nursing home) subject to the conditions described below.

We pay for services for the terminally ill provided through a participating hospice program. Hospice care services are payable for four 90-day periods. To be payable, the following criteria must be met:

- The patient or his or her representative elects hospice care services in writing. This written statement must be filed with a participating hospice program.

- The following certifications are submitted to BCBSM:

  For the first 90 days of hospice care coverage:

  A written certification stating that the patient is terminally ill, signed by the:

  – Medical director of the hospice program **or**
  – Physician of the hospice interdisciplinary group **and**
  – Attending physician, if the patient has one

  For the second 90-day period (submitted no later than two days after this 90-day period begins):

  The hospice must submit a **second** written certification of terminal illness signed by the:

  – Medical director of the hospice **or**
  – Physician of the hospice interdisciplinary group

  For the third 90-day period (submitted no later than two days after this 90-day period begins):

  The hospice must submit a **third** written certification of terminal illness signed by the:

  – Medical director of the hospice **or**
  – Physician of the hospice interdisciplinary group

  For the fourth 90-day period (submitted no later than two days after this 90-day period begins):

  The hospice must submit a **fourth** written certification of terminal illness signed by the:

  – Medical director of the hospice **or**
  – Physician of the hospice interdisciplinary group

Hospice Care Services (continued)

- The patient or his or her representative must sign a "Waiver of Benefits" form acknowledging that the patient has been given a full explanation of hospice care. This waiver confirms the patient's (or family's) understanding that regular Blue Cross Blue Shield benefits for conditions related to the terminal illness are not in force while hospice benefits are being used.

BCBSM benefits for conditions not related to the terminal illness remain in effect.

We pay for:

Counseling, evaluation, education and support services for the patient and his or her family from the hospice staff before the patient elects to use hospice services. These services are limited to a 28-visit maximum.

When a patient elects to use hospice care services, regular BCBSM coverage for services in connection with the terminal illness and related conditions are replaced by the following:

Home Care Services

- Up to eight hours of routine home care per day
- Continuous home care for up to 24 hours per day during periods of crisis
- Home health aide services provided by qualified aides. These services must be rendered under the general supervision of a registered nurse.

Facility Services

- Inpatient care provided by:
  - A participating hospice inpatient unit
  - A participating hospital contracting with the hospice program or
  - A skilled nursing facility contracting with the hospice program
- Short-term general inpatient care when the patient is admitted for pain control or to manage symptoms. (These services are payable if they meet the plan of care established for the patient.)
- Five days of occasional respite care during a 30-day period

Hospice Care Services (continued)

We pay for: (continued)

Hospice Services

- Physician services by a member of the hospice interdisciplinary team
- Nursing care provided by, or under the supervision of, a registered nurse
- Medical social services by a licensed social worker, provided under the direction of a physician
- Counseling services to the patient and to caregivers, when care is provided at home
- BCBSM-approved medical appliances and supplies (these include drugs and biologicals to provide comfort to the patient)
- BCBSM-approved durable medical equipment furnished by the hospice program for use in the patient's home
- Physical therapy, speech and language pathology services and occupational therapy when provided to control symptoms and maintain the patient's daily activities and basic functional skills
- Bereavement counseling for the family after the patient's death

The above services are limited to a maximum amount that is reviewed and adjusted periodically. Once you reach the maximum, hospice benefits will continue to be covered under the case management program. Please call us for information about the current maximum amount.

Professional Services

- Provided by the attending physician to make the patient comfortable and to manage the terminal illness and related conditions

Payable services do not include physician services provided by a member of the hospice interdisciplinary team.

Payment for professional services is limited to a maximum amount, determined by BCBSM, which is reviewed and adjusted periodically. Once you reach the maximum, hospice benefits will continue to be covered under the case management program. Please call us for information about the current maximum amount. This amount is separate from, and not included in, the limit for the hospice program services described above.

Hospice Care Services (continued)

We pay for: (continued)

How to Cancel or Reinstate Hospice Care Services

Hospice care services may be canceled at any time by the patient or his or her representative. Simply submit a written statement to the hospice. When the services are canceled, regular Blue Cross Blue Shield coverage will be reinstated.

Hospice care services may be reinstated at any time. The patient is reinstated for any remaining period for which he or she is eligible.

We do not pay for services:

- Other than those furnished by the hospice program. (Remember, the services covered are those provided primarily in connection with the condition causing the patient's terminal illness.)
- Of a hospice program other than the one designated by the patient. (If the designated program arranges for the patient to receive the services of another hospice program, the services are covered.)
- That are not part of the plan of care established by the hospice program for the patient